

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10273

10283

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. RURAL TOWN (If outside corporate limits, write RURAL and give nearest town) <u>German town</u> KFD 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Gilbert</u>		First <u>Gilbert</u>	Middle <u>Block</u>
4. DATE OF DEATH <u>October 13 1956</u>		Month <u>October</u>	Day <u>13</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <u>April 15, 1956</u>
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) yrs. <u>5</u> IF UNDER 1 YEAR Months <u>28</u> IF UNDER 24 HRS. Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer D. Allgood</u>		14. MOTHER'S MAIDEN NAME <u>Patricia King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheo - bronchitis, Fulminant</u> DUE TO <u>500</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u>	
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Frederick</u> (County) <u>Maryland</u> (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>13 Oct 1956</u> to <u>13 Oct 1956</u> , that I last saw the deceased alive on <u>13 Oct 1956</u> , and that death occurred at <u>8 1/2 M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>A. M. Powell, M.D.</u> ADDRESS <u>220 N. Market St.</u> DATE SIGNED <u>14 Oct 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 15, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Salem Methodist</u>		22d. LOCATION (City, town, or county) <u>Cedar Grove, Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molsworth</u>		24a. REC'D BY REGISTRAR ADDRESS <u>Damascus, Md.</u> DATE <u>16 Oct 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hech</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar on page 3 should it be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with a burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

RECEIVED

DEPARTMENT OF HEALTH-DEPARTMENT OF

BUREAU V. S.

OCT 18 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10274

10284

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		b. COUNTY <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>Rural - Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Frederick</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>		d. STREET ADDRESS <b>R.F.D. # 2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Bessie</b>	Middle <b>May</b>	Last <b>Ausherman</b>
4. DATE OF DEATH	Month <b>October</b>	Day <b>30</b>	Year <b>1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1896</b>
9. AGE (In years lost birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Suman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>John M. Ausherman, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		1-2 yrs.	
DUE TO (c)		1-2 yrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 1956, to <b>Oct. 30</b> , 1956, that I last saw the deceased alive on <b>10-30-1956</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Rex R. Martin MD</b>		ADDRESS (Street, city or town, state) <b>35 E. Church</b>	
PHYSICIAN'S NAME (Type) <b>Rex R. Martin</b>		DATE SIGNED <b>10-30-56</b>	
22a. BURIAL, CREMATION, BURIAL (Specify) <b>Buriel</b>	22b. DATE THEREOF <b>Nov. 1, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molesworth</b>	ADDRESS <b>Damascus, Md.</b>	24a. REC'D BY REGISTRAR DATE 2 Nov, 1956	24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Herk</b>

ST. LOUIS COUNTY, MISSOURI - SEPTEMBER 12

CHARGE SHEET

SEARCHED	INDEXED	SEARCHED	INDEXED
SERIALIZED	FILED	SERIALIZED	FILED
NOV 5 1956			
FBI - ST. LOUIS			
FEDERAL BUREAU OF INVESTIGATION			
U. S. DEPARTMENT OF JUSTICE			
RECEIVED			

FEDERAL BUREAU OF INVESTIGATION

NOV 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove the 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10275

10285

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE MICHAEL BARRICK</b>		d. STREET ADDRESS <b>44 LIBERTY ST.</b>	
4. SEX <b>M</b>	5. COLOR OR RACE <b>W</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>3-10-56</b>
8. DATE OF DEATH <b>10 23 1956</b>	9. AGE (in years lost birthday) yrs. <b>71</b>	10. IF UNDER 1 YEAR Months <b>7</b>	11. IF UNDER 24 HRS. Days <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES E. BARRICK</b>		14. MOTHER'S MAIDEN NAME <b>JUNE Bloom</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charlie &amp; Barrick Westminster, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERITONITIS</b>	
DUE TO <b>571.0</b>		Address <b>5 Bond St</b>	
Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>COLITIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>	
DUE TO <b>COLITIS</b>		?	
(c)		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-21, 1956</b> , to <b>10-23, 1956</b> , that I last saw the deceased alive on <b>10-23, 1956</b> , and that death occurred at <b>6:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>220 N. Mulberry St.</b> DATE SIGNED <b>10-23-56</b>			
ACTUAL SIGNATURE <b>Frederick J. Heidrich Jr.</b>			
PHYSICIAN'S NAME (Type) <b>FRED J. HEIDRICH JR.</b>			
22a. BURIAL Cremation, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-23-56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>St. John's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Westminster Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Barbara &amp; Son Westminster Md.</b>		ADDRESS <b>2134-211 XVII</b>	
24a. REC'D BY REGISTRAR DATE <b>26 Oct 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heidrich</b>	

RECEIVED - DEPARTMENT OF DEFENSE

BUREAU V.

OCT 29 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10276

10314

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First MINNIE	Middle CATHERINE	Last BLESSING	4. DATE OF DEATH	Month October	Day 7	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 19 Dec 1867		9. AGE (in years last birthday) 88	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Blessing				14. MOTHER'S MAIDEN NAME Vallietta Adams				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Minnie S. Keller (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. DUE TO (b) Arterio - Sclerotic heart dis.						INTERVAL BETWEEN ONSET AND DEATH / month ? years.		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 9040 Senile Astheno spract. rt. humerus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. n. July 30 1956 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House		20f. (City or town) Buckeystown, Fred., Md. (County) (State)		
21. I certify that I attended the deceased from 30 July 1956, to 10 Oct 1956, that I last saw the deceased alive on 30 Sept. 1956, and that death occurred at 1:30A M, from the causes and on the date stated above. ACTUAL SIGNATURE Charles H. Conley, Jr., M. D.						ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 10/8/56		
22a. BURIAL, CREMATION, ETC. (Specify) Burial		22b. DATE THEREOF 10 Oct 1956		22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 9 Oct 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Herk		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - GOVERNMENT OF THE REPUBLIC OF GHANA

RECEIPT OF DOCUMENT

RECEIVED  
BUREAU Y.  
OCT 10 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10277

## 10315 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D. #4				c. LENGTH OF STAY IN 1b Years				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willis Derr Road				d. STREET ADDRESS Willis Derr Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First FLORENCE	Middle ELIZABETH	Last BOYER	4. DATE OF DEATH October 25, 1956	Month October	Day 25	Year 1956
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1878	9. AGE (in years lost birthday) 77	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel Whipp				14. MOTHER'S MAIDEN NAME Mary Jane Myers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Howard T. Boyer, Frederick R. D. #4, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 days.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hypertension						
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Sept 20, 1956</u> to <u>Oct 24, 1956</u> that I last saw the deceased alive on <u>Oct 24, 1956</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. North Market St., Frederick, Md. 10/26/56 DATE SIGNED								
ACTUAL SIGNATURE <u>H.F.Kline</u> PHYSICIAN'S NAME (Type) Dr. H.F.Kline Sr. Same as above								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Lutheran Cem.		22d. LOCATION (City, town, or county) Feagerville, (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 26 Oct 1956		24b. REGISTRAR'S SIGNATURE Elizabeth H. Hesk		

CHIEF STATE OF DEATH

BUREAU V. S

OCT 29 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10278

Reg. Dist. No.

**10316**

1. PLACE OF DEATH  
 a. COUNTY

*Frederick*

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL  
 and give nearest town)

*Frederick, Md.*

c. LENGTH OF STAY IN 18

*61 yrs*

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

*P.D. Mt. P. R.R.*

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE *Maryland*

b. COUNTY *Frederick*

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

*Frederick, Md.*

d. STREET ADDRESS

*P.D. Mt. P. R.R.*

e. IS RESIDENCE  
 ON A FARM?  
 YES  NO

3. NAME OF  
 DECEASED  
 (Type or print)

First *Martha* Middle *Bell Bradshaws* Last

4. SEX

*Female*

6. COLOR OR RACE

*White*

7. MARRIED  NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

*Divorced* *Jan. 7, 1872*

9. AGE (In years  
 last birthday)

*84* yrs.

10. FUNDER 1YEAR:

Months *1* Days *0*

11. IF UNDER 24 HRS.

Hours *0* Min. *0*

10a. USUAL OCCUPATION (Give kind of work done  
 during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

*over home*

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

*US*

13. FATHER'S NAME

*Asa*

*H. R. Bradshaws*

14. MOTHER'S MAIDEN NAME

*Catherine*

*Clay*

Address *Front Ferry Rd.*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

*NO*

16. SOCIAL SECURITY NO.

*—*

17. INFORMANT

*Norman Bradshaws*

INTERVAL BETWEEN  
 ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*420.1*

*Chronic Obstruction*

DUE TO

Conditions, if any, which  
 gave rise to immediate cause

(a), stating the underlying  
 cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
 PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS

PRIMARY  OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.

p. m.

20d. INJURY OCCURRED

While at work

Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and find that

death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause

ACTUAL

SIGNATURE *B. C. Thomas*

M.D. CHIEF MEDICAL EXAMINER

SIGNED

EXAMINER'S

NAME (Type) *B. C. Thomas*

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Oct. 5, 1956

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

*10-8-1956*

22c. NAME OF CEMETERY OR CREMATORIUM

*Methodist Chapel*

22d. LOCATION (City, town, or county)

*Frederick, Md.*

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

*C. M. Lantz Winfield, Md.*

24a. REC'D BY REGISTRAR

*Oct. 8, 1956*

DATE

*Oct. 8, 1956*

24b. REGISTRAR'S SIGNATURE

*Oct. 8, 1956*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the registrar. File Pages 1 and 2 with the registrar prior to removal.

WADY S.

OCT 8 1980

7000

1028 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10279

Reg. Dist. No. 131

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained by your funeral director. File Pages 1 and 2 with the registrar prior to removal.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 Day		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In Front of 21 East Church Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 43 South Prospect Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREDERICK CHARLES BREITENOTHER, SR.		First	Middle	Last	4. DATE OF DEATH Month October 25, 1956	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Butcher		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis Frederick Breitenother		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WV1		17. INFORMANT ?		Address 73 South Prospect Ave., Catonsville 28, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (b) (c)		DUE TO 420.1		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 25 Oct 1956			
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Faltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE George L. Schawb, 2101 Frederick Ave., Balt. 23, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 26 Oct 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Hech			

BUREAU V. S.

CT 1956

REGELVALE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10287

## CERTIFICATE OF DEATH

10280  
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 16 Year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 620 Trail Avenue		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ESTHER		First	Middle	4. DATE OF DEATH October 2, 1956	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1893		9. AGE (In years lost birthday) 62 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Charles E. Kinna				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Guy V. Burkett, Frederick, Maryland		Address 620 Trail Avenue, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 1 hr							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 12, 1956</u> to <u>Oct 2, 1956</u> that I last saw the deceased alive on <u>Oct 2</u> 1956, and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. East Second St., Frederick, Md. DATE SIGNED 10/4/56							
ACTUAL SIGNATURE <u>H. Lawrence Fahrney</u>							
PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney							
Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Frederick Memorial Park		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 5 Oct 1956	
						24b. REGISTRAR'S SIGNATURE Elizabeth Etchison	

HOSPITAL  PHYSICIAN  DIRECTOR  REGISTRAR  The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNAU V. S.

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DEAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10288 CERTIFICATE OF DEATH

10281

Reg. Dist. No. 131

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			b. COUNTY Frederick		
c. LENGTH OF STAY IN 1b Since 1914			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			d. STREET ADDRESS 120 East Seventh Street		
3. NAME OF DECEASED (Type or print) HARVEY HAMILTON CARMACK			4. DATE OF DEATH Month Day Year October 8, 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 27 Sept 1893	9. AGE (In years last birthday) 63 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Confectionery		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Valentine S. Carmack			14. MOTHER'S MAIDEN NAME Mary C. Heffner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) Yes			16. SOCIAL SECURITY NO. 17. INFORMANT 217-10-9452 Mrs. Annie M. Carmack (Same as item #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause first. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hr		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1956, 19, to Oct 8, 1956, that I last saw the deceased alive on Oct 7, 1956, and that death occurred at 5:30A M, from the causes and on the date stated above.			ADDRESS (Street, city or town, state) DATE SIGNED M.D. 228 N. Market St., Frederick, Md. 10/9/56		
ACTUAL SIGNATURE <i>Dr. B. O. Thomas</i>					
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.					
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11 Oct 1956	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE 9 Oct 1956		
			24b. REGISTRAR'S SIGNATURE <i>Elizabeth S. Heffner</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10317

10282

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Frederick</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>		c. LENGTH OF STAY IN 1b <i>33 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville, Md.</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WINFIELD SCOTT CROMWELL</b>		First	Middle	Last	4. DATE OF DEATH <b>Oct.</b>	Month	Day	Year
5. SEX <b>m</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1871</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>live Stock dealer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Employed</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Arthur H. Cromwell</i>		14. MOTHER'S MAIDEN NAME <i>Harriete Etzler</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Ray Cromwell, Walkersville, Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral thrombosis				INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Gangrene toes, secondary to (b)</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>1 July</i> , 1956 to <i>8 October</i> , 1956 that I last saw the deceased alive on <i>8 October</i> , 1956, and that death occurred at <i>12 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>James E. Stoner Jr.</i>		M.D.				DATE SIGNED <i>9 October 1956</i>		
PHYSICIAN'S NAME (Type)		JAMES E. STONER, Jr.		WALKERSVILLE, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 10, 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Hope</i>		22d. LOCATION (City, town, or county) <i>Woodstock</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton, Walkersville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>10 Oct 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Elig. H. H. Hark</i>		

BUREAU Y. A.

OCT 15 1956

PROGRESSIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10289

## CERTIFICATE OF DEATH

10283

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 187 West All Saints Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 187 West All Saints Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ISABELLA		First MAE	Middle DALEY	Last DALEY	4. DATE OF DEATH October 26, 1956	Month October	Day 26	Year 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> December 30, 1883	9. AGE (In years last birthday) 72 yrs	10. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry E. Turner			14. MOTHER'S MAIDEN NAME Roda Heights						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William H. Daley, Frederick, Maryland		187 West All Saints Street		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost.			Acute myocardial infarction immediate (b) DUE TO Cerebral & Generalized arteriosclerosis 1 year (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. East Church St., Frederick, Md.		(County)	(State)
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Oct 26, 1956</u> , that I last saw the deceased alive on <u>Oct 15, 1956</u> , and that death occurred at <u>9:00A M</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Rex R. Martin</u> DATE SIGNED <u>10/27/56</u>									
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. RECD BY REGISTRAR DATE 29 Oct 1956		24b. REGISTRAR'S SIGNATURE Elizabeth H. Head			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director.  
The registrar price of \$3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Yes 1 and 2 should be filed with the registrar price of \$3.

BUREAU V. S.

OCT 1956

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be required by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 10318 CERTIFICATE OF DEATH 10284

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		c. LENGTH OF STAY IN lb 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Oma	Middle Grace	Last Eyler
4. DATE OF DEATH	Month October	Day 8	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1903
9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. FATHER'S NAME Edward Ridenour	14. MOTHER'S MAIDEN NAME Clara Wetzel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Lloyd A. Eyler	Address Thurmont RD2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension</i> DUE TO (b) <i>Cardio-vascular-renal disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Carcinoma of uterine cervix</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day 19	Year 1956
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Thurmont	(County) Maryland
21. I certify that I attended the deceased from <i>Oct. 1</i> , 1956, to <i>Oct. 8</i> , 1956, that I last saw the deceased alive on <i>Oct. 8</i> , 1956, and that death occurred <i>6:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M. Franklin Birely</i>	ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 10/17/56		
PHYSICIAN'S NAME (Type) Dr. M. Franklin Birely	DATE SIGNED		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 10-11-56	22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cem.	22d. LOCATION (City, town, or county) Thurmont (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE 10-17-1956	24b. REGISTRAR'S SIGNATURE <i>A. H. Dredrich</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10285

10319

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baldock Heights</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindobona Convalescent Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) <b>BENJAMIN</b>		First <b>F.</b>	Middle <b>GROFF</b>
4. DATE OF DEATH <b>October 2 1956</b>	Month <b>October</b>	Day <b>2</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 25, 1874</b>
9. AGE (In years last birthday) <b>81</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Conductor</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>David Groff</b>		14. MOTHER'S MAIDEN NAME <b>Melinda Coblentz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>217-10-9241</b>	17. INFORMANT <b>Mrs. Benjamin F. Groff - 137 W. Patrick St., Frederick, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  (b)  (c)		DUE TO  <i>at Mengleman Central Mem. Hosp.</i> <i>Chr. Hypertension + arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>5 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>Oct</b>	Day <b>19</b>	Year <b>1956</b>
20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Middletown</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Sept 25</b> , 1956, to <b>Oct 2</b> , 1956, that I last saw the deceased alive on <b>Oct 1</b> , 1956, and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Laurence Fahrney</i>	M.D.		ADDRESS (Street, city or town, state) <b>Frederick Md.</b>
PHYSICIAN'S NAME (Type) <b>Dr. Laurence Fahrney</b>	DATE SIGNED <b>10-3-56</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 4, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Lutheran Cemetery</b>	22d. LOCATION (City, town, or county) <b>Middletown</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline &amp; Son</i>	W <sup>1</sup> ADDRESS <i>Frederick - Md.</i>	24a. REC'D BY REGISTRAR DATE <b>Oct 1956</b>	24b. REGISTRAR'S SIGNATURE <i>Elig. H. G. Heis</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10286

10298

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick				MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 502 North Market Street				d. STREET ADDRESS 502 North Market Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LESTER		First EDWARD		Middle HALLER		4. DATE OF DEATH October 1, 1956		Month October	Day 1	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH January 1, 1900		9. AGE (In years last birthday) 56 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Store				10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Haller				14. MOTHER'S MAIDEN NAME Gertrude Titus							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frances S. Haller, Frederick, Maryland		Address 502 North Market Street, Frederick, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Professional Bldg., Frederick, Md.		(County)		(State) Maryland		
21. I certify that I attended the deceased from <u>January</u> , 1956, to <u>October</u> , 1956, that I last saw the deceased alive on <u>Sept. 30</u> , 1956, and that death occurred at <u>7:00A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Professional Bldg., Frederick, Md. 10/1/56 DATE SIGNED											
ACTUAL SIGNATURE <u>B. O. Thomas Sr.</u>											
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Sr.		Same as above									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 3, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland				(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE Oct 1956		24b. REGISTRAR'S SIGNATURE Elizabet B. Heib			

**DO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be revised by the hospital or attending physician.

**COINEREAU DIRECTOR:** After this certificate has been signed by the attending physician and completed, file it in the funeral director's office. It should be checked for use as the burial-transit permit. Then please remove carbon papers. File the original, and in any event within 72 hours after death, hand the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 10287  
13

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10320

### CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick R.D. # 2</b>		c. LENGTH OF STAY IN 16 <b>12 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cemetery Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) <b>Clarence</b>		First <b>Philip</b>	Middle <b>Handley, Sr</b>
4. DATE OF DEATH <b>Oct 3 1956</b>	Month <b>Oct</b>	Day <b>3</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug 17 1893</b>
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years lost birthday) <b>63 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electric Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marshall P. Handley</b>		14. MOTHER'S MAIDEN NAME <b>Martha B. Babylon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>211-10-3374</b>	
17. INFORMANT <b>Mrs Fannie M. Handley</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with decompensation</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Carcinoma of Prostate with metastases to pelvis + spine</b>	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1956, to <b>Oct 3</b> , 1956, that I last saw the deceased alive on <b>Oct. 3</b> , 1956, and that death occurred at <b>10:55 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>East Church St., Frederick, Md.</b>	
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b>		DATE SIGNED <b>10/5/1956</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Robert S. Turner M.D.</b>		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 6, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Meadow Brook Cemetery</b>		22d. LOCATION (City, town, or county) <b>Westminster</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M.R. Etchison and Son</b>		24a. REC'D BY REGISTRAR <b>Elizabeth G. Heck</b>	
ADDRESS <b>Frederick, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10288

10291

## **CERTIFICATE OF DEATH**

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN lb <b>18 Years</b>				b. COUNTY <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>230 Dill Avenue</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				d. STREET ADDRESS <b>230 Dill Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>MAUD</b>				First <b>ELIZABETH</b>		Middle <b>HARP</b>		4. DATE OF DEATH <b>October 9, 1956</b>		Month Day Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 11, 1876</b>		9. AGE (In years lost birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Alexander Glenn</b>				14. MOTHER'S MAIDEN NAME <b>Laura K. Colliflower</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>Mr. Hubert A. Harp, Sr.,</b>		230 Dill Avenue, Frederick, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.n. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hagerstown</b>		(County) <b>Hagerstown</b>		(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Oct. 8</b> , 1956, to <b>Oct. 9</b> , 1956, that I last saw the deceased alive on <b>Oct. 8</b> , 1956, and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Hagerstown, Maryland</b>				DATE SIGNED <b>10/11/56</b>			
ACTUAL SIGNATURE <b>Bernard O. Hausey</b>		M.D. Professional Bldg., Frederick, Md.									
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas Jr.</b>				Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>Oct. 12, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>Elmwood Bldg., Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>Elmwood Bldg., Frederick, Maryland</b>			
								24b. REGISTRAR'S SIGNATURE <b>Elmwood Bldg., Frederick, Maryland</b>			

**TO PHYSICIAN OR ATTENDING PHYSICIAN:** This form requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, file in the funeral director's office. Please remove carbon papers. File in any event within 72 hours after death.

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OCT 12 1956

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

10321

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy, Rt.</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy, RFD #4, Harrisville Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Albert</b>	Middle <b>Eugene</b>	Last <b>Harris</b>
4. DATE OF DEATH	Month <b>Oct.</b>	Day <b>22</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 9, 1911</b>
9. AGE (In years less birthday) <b>45</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland, U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Thomas Harris</b>	14. MOTHER'S MAIDEN NAME <b>Jenny Elizabeth Wermert</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>218-10-9269</b>		17. INFORMANT <b>John David Harris, Mt. Airy, Md.</b>	Address <b>Rt. 4</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.		<b>Acute Coronary Artery Thrombosis.</b>	
DUE TO (b) (c)		<b>Arterosclerotic Heart Disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>October 23, 1956</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-25-1956</b>	22c. NAME OF CEMETERY OR CEMMATORI <b>Leisters</b>	22d. LOCATION (City, town, or county) <b>Carroll Co., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>	ADDRESS <b>Winfield, Md.</b>	24a. RECEIVED BY REGISTRAR <b>JUL 20 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Clarence Runkless</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Examiner or the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director for filing with the registrar prior to removal.

BEREAU V.

OCT 25 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 or 2 should be filed with the registrar. Page 3 should be filed with the funeral director, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10322

### CERTIFICATE OF DEATH

10290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		b. COUNTY	
c. LENGTH OF STAY IN 1b 46 yrs.		Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Thurmont	
First Charles		d. STREET ADDRESS Route 1	
Middle Christian Hauver		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH	Month October	Day 27
S SEX male	5. COLOR OR RACE white	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DATE OF BIRTH March 23, 1867
8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 89 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ephrim Hauver	
14. MOTHER'S MAIDEN NAME Ellen Gorden		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO 215-14-2809		17. INFORMANT Mrs. Mary C. Hauver Thurmont RD1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral Hemorrhage		5 yrs. (c) DUE TO Cerebral Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 23, 1956, to Oct 27, 1956, that I last saw the deceased alive on Oct 26, 1956, and that death occurred at 5:10 p. M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. James K. Gray		ADDRESS (Street, city or town, state) Thurmont, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-56	
22c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge Cemetery		22d. LOCATION (City, town, or county) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond G. Creager		ADDRESS Thurmont, Md.	
24a. REG'D BY REGISTRAR Nov 1 1956		24b. REGISTRAR'S SIGNATURE John A. K. Gray	

PEREA V. G.

OV 1 1956

PEREA V. G.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10291

Reg. Dist. No. 131

10292

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose letter, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director. Page 6 should be used as a burial-troumal Permit. File pages 1 and 2 with the registrar prior to burial, if removal.

1. PLACE OF DEATH a. COUNTY		10292		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE		Maryland		
Frederick		MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Frederick		4 Years		Frederick		811 Motter Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?				
Frederick Memorial Hospital		811 Motter Avenue		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
		THOMAS	EDWARD	JACKSON	October 20, 1956			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	31 May 1877	79 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired Owner		General Hauling		Maryland		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Greenberry Jackson		Elizabeth Gray						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		None		Mrs. Blanche B. Jackson		(Same as item #2)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema								
DUE TO (b) Diabetus <i>This condition was</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO (c) Arterosclerosis <i>precipitated by fracture</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell At Home--Fracture Left Hip						
20c. TIME OF INJURY Hour a. m. 10 10. Oct 3, 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Frederick-Frederick-Maryland		(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		B. O. Thomas, M. D.						
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 22 Oct 1956						
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 23 Oct 1956		22c. NAME OF CEMETERY OR CREMATORIUM Potomac Cemetery		22d. LOCATION (City, town, or county) Montgomery County Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Fitchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 22 Oct 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hock		

BOURGEOIS, E.

DEC 3 1956

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10292

10293

## CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial twsp.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Market</b>	
3. NAME OF DECEASED (Type or print) <b>Lewis</b>		d. STREET ADDRESS	
4. DATE OF DEATH <b>Oct. 13 1956</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years lost birthday) <b>83 yrs</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Lewis JAMES, Jr.</b>		Address <b>New Market</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Pyonephrosis, Cerebral Hemorrhage/34/3 days Hyper trophy of Prostate 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Arteriosclerosis, Sickle Cell Anemia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> , p. m. <b>19</b>		20d. INJURY OCCURRED While <b>Not while</b> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>New Market</b> (State)	
21. I certify that I attended the deceased from <b>Aug 4, 1956</b> , to <b>Oct 13, 1956</b> , that I last saw the deceased alive on <b>Oct. 12, 1956</b> , and that death occurred at <b>230 M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>New Market</b> DATE SIGNED <b>Ralph L. Michels M.D.</b>			
ACTUAL SIGNATURE <b>Ralph L. Michels</b>		PHYSICIAN'S NAME (Type) <b>Ralph L. Michels M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT 15-62</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>SIMPSONS CHAPEL</b>		22d. LOCATION (City, town, or county) (State) <b>NEW MARKET MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Falcone</b>		ADDRESS <b>New Market MD</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 15-54</b>		24b. REGISTRAR'S SIGNATURE <b>Lucius K. Falcone</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
RECORDS: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director.  
It should be retained for use as the burial-transit permit. Then please remove carbon papers. It should be filed with  
the funeral director, or cremation, or removal, and in any event within 72 hours after death.

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OCT 18 1958

BUREAU A. A.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10293

10294

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Effie		First Louise	Middle Timpson
3. NAME OF DECEASED (Type or print) Effie		Last Johnson	4. DATE OF DEATH October 23,
S SEX Female	6 COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> June 8, 1903	8. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	9. IF UNDER 1 YEAR Months Days Hours Min
13. FATHER'S NAME George Timpson		11. BIRTHPLACE (State or foreign country) Frederick, Co. Md.	12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 219-05-5069	17. INFORMANT Charles E. Palmer 13 W. All Saints St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>14 October 1956</u> , to <u>23 October 1956</u> , that I last saw the deceased alive on <u>23 October 1956</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE James B. Thomas M.D.			
PHYSICIAN'S NAME (Type) James Thomas		Professional Building Frederick, Maryland	
22a. BURIAL, CREMATION, REMAINS (Specify) Burial		22b. DATE THEREOF Oct. 27-56	22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls
22d. LOCATION (City, town, or county) Della - Frederick, Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick, Md.		24a. REC'D BY REGISTRAR DATE 36 Oct 1956	24b. REGISTRAR'S SIGNATURE Eligible by Hock

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4  
 may be read by the hospital or attending physician and completed in the funeral director, the funeral director, After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10294

10323

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Nr. Lander		c. LENGTH OF STAY IN 1b 4 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		b. COUNTY	
Frederick MARYLAND						Maryland		Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Glenmerrie Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
3. NAME OF DECEASED (Type or print)		First ADA		Middle B.		4. DATE OF DEATH		Month October	
						KENNER		Day 12	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		June 28, 1864		92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own home		Washington, D. C.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Joseph E. Crandell		Martha Greer							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		None		Mrs. E. B. Parkinson - 220 Lindbergh Avenue		Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH			
		DUE TO				3 days.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)							
		DUE TO							
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		Dr. B. O. Thomas, Jr.		M.D.		DATE SIGNED Frederick, Md. Oct 13, 56			
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-15-1956		22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Nr. Washington, D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son - Frederick - Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 15 Oct 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hock			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be referred by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

ALLEGRA V. S.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10295

131  
Reg. Dist. No.

10324

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director. File pages 1 and 2 with the registrar plus 1 and 2 with the medical examiner. File page 3 as a burial-transit permit.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattstown</b>		c. LENGTH OF STAY IN lb <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattstown</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WALTER</b>	Middle <b>NORWOOD</b>	Last <b>LAWSON</b>	4. DATE OF DEATH	Month <b>October 31,</b>	Day <b>1956</b>	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Nov 1893</b>	9. AGE (In years last birthday) <b>62 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Crittenden Lawson</b>		14. MOTHER'S MAIDEN NAME <b>Alice Norwood</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mrs. Noble Lawson, Hyattstown, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broken neck</i> INTERVAL BETWEEN ONSET AND DEATH  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>fall from tree</i> minutes  DUE TO  (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from Tree</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:30 P.M. Oct. 31, 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hyattstown-Frederick-Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>1 Nov 1956</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3 Nov 1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Burdette, Hyattstown, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Elizabeth H. Heck</b>		24b. REGISTRAR'S SIGNATURE	
				DATE <b>1 Nov. 1956</b>			

BUREAU V. S.

NOV 5 1962

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10296

10295

Reg. Dist. No.

131

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your funeral director. Your funeral director or removal.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)																											
Frederick				a. STATE Maryland																											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY Frederick																											
Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS																											
Frederick Memorial Hospital				1375, Hunt																											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																															
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year																							
Male		Gregory	Edward	Lease	October	10	1956																								
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.																			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/23/1949		7 yrs.		Months		Days		Hours		Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?																			
EN School				—				Maryland				U.S.																			
13. FATHER'S NAME									14. MOTHER'S MAIDEN NAME																						
William J. Lease									Cynthia Raines																						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)									16. SOCIAL SECURITY NO.																						
(If yes, give war or dates of service)									17. INFORMANT																						
—									—																						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH																						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)									Gun Shot in rt lung																						
DUE TO									Minutes																						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first																															
(b)																															
DUE TO																															
(c)																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY				Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.)				20f. (City or town)				(County)		(State)	
Hour 4:30 p.m.				Shot by 22 caliber rifle				While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				10/10 1956				Frederick				Frederick		Co		Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																															
ACTUAL SIGNATURE									M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>																						
EXAMINER'S NAME (Type)									ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																						
B.C. Thomas									DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																						
22a. BURIAL, Cremation, Removal (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORIUM				22d. LOCATION (City, town, or county)																			
Burial				10-13-1956				Marvin Chapel				Frederick Co																			
(State)																															
23. FUNERAL DIRECTOR'S SIGNATURE									ADDRESS									24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE									
C.M. Waetz									Winfield, Md.									DATE 13 Oct 1956				Elizabeth S. Hebb									

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OCT 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10297

10296

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 18 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural-R. F. D. #1				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Flint Hill		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOHN		First	Middle	Last	4. DATE OF DEATH LENHART	Month	Doy	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1902	9. AGE (In years last birthday) 54	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fertilizer Comp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel Lenhart				14. MOTHER'S MAIDEN NAME Flora Soper				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-34-3862		17. INFORMANT Mrs. Virginia P. Lenhart, Adamstown R.F.D. #1, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		CURENIA				INTERVAL BETWEEN ONSET AND DEATH 18+days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Hypertensive heart disease				2+years.		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I attended the deceased from 24 Sept., 1956, to 11 Oct., 1956, that I last saw the deceased alive on 11 Oct., 1956, and that death occurred at 11:58 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Professional Bldg., Frederick, Md. 10/13/1956 DATE SIGNED								
ACTUAL SIGNATURE Dr. Charles H. Conley Jr.		Same as above						
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL? (Specify) Burial		22b. DATE THEREOF Oct. 15, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Urbana Methodist Cemetery		22d. LOCATION (City, town, or county) Urbana		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. R. Etchison & Son, Frederick, Maryland		ADDRESS DATE 15 Oct 1956						
		24a. REC'D BY REGISTRAR Eliz. Smith & Herk						
		24b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be requested by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, and a copy should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death.

REGISTRAR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event within 72 hours after death.

SHULTAU V. S.

OCT 1 1962

REGISTRY  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to 12:00 noon. If it is filed after 12:00 noon, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Forms 1 and 2 should be filed with the registrar prior to 12:00 noon.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 will be checked in the funeral director.

10298

10297

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>57 yrs</i>			
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <i>Visitation Cemetery</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>			
3. NAME OF (SISTER) First Middle Last (Type or print) <i>Augustine M. Lutz</i>		4. DATE OF DEATH <i>Oct 17</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Jan 26 1879</i>	9. AGE (In years from last birthday) <i>77 yrs.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Belgian</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cemetery</i>			
10c. BIRTHPLACE (State or foreign country) <i>W. Va</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Engelbert Lutz</i>		14. MOTHER'S MAIDEN NAME <i>Ada Bassell</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Records of Visitation Cemetery Frederick, Md</i>		Address <i>—</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute dilatation of the heart</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>—</i>		9 years.			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>Oct 16</i> , 1956, to <i>10/17/56</i> , that I last saw the deceased alive on <i>10/16/56</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4 E. Church St., Frederick, Maryland.</i>					
DATE SIGNED <i>10/17/56</i>					
ACTUAL SIGNATURE <i>Wm. M. Smith</i>					
PHYSICIAN'S NAME (Type) <i>Wm. M. Smith</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/18/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Visitation</i>	22d. LOCATION (City, town, or county) <i>Frederick</i>	(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry E. Baughman, Frederick, Md</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR DATE <i>18 Oct 1956</i>	
				24b. REGISTRAR'S SIGNATURE <i>Elizabeth L. Heck</i>	

BUREAU V. S.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Funeral Director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10299  
Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>12 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Frederick Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
f. STREET ADDRESS <b>261 West Patrick Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EUGENE CALVIN MERCER</b>		4. DATE OF DEATH <b>October 17, 1956</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 May 1877</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bailiff</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Circuit Court</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Mercer</b>		14. MOTHER'S MAIDEN NAME <b>Albina Gibbons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Nellie Mercer (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>400.1</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b> </b>			
DUE TO <b> </b> (c) <b> </b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>p. m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>
20f. (City or town) <b> </b>		(County) <b> </b> (State) <b> </b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED <b>19 Oct 1956</b>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>20 Oct 1956</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>Elizabeth S. Herk</b>	
ADDRESS <b> </b>		24b. REGISTRAR'S SIGNATURE <b> </b>	
DATE <b>19 Oct 1956</b>			

BUREAU V. S.

OCT 19 1968

FILE NUMBER

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10300

Reg. Dist. No. 121

10299		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		b. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knocksville	
3. NAME OF DECEASED (Type or print) Charles Theodore Meyer		4. DATE OF DEATH Month October Day 18 Year 1956	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH December 1, 1874	
9. AGE (In years and months) 87 yrs.		10. IF UNDER 1 YEAR Months	
11. BIRTHPLACE (State or foreign country) Indiana		12. IF UNDER 24 HRS. Days Hours Min.	
13. FATHER'S NAME Albert Meyer		14. MOTHER'S MAIDEN NAME Dont know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ada Meyer, Knoxville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Ribs, Crushed on left side, Fracture of both legs. Pneumonia of upper lobes			
DUE TO (b) of both lungs			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Automobile accident on high way	
20c. TIME OF INJURY Month, Day, Year Hour 12:30 p.m. 10/11/56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Route 340		20f. (City or town) Petersville (County) Frederick (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas		10/19/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-56	
22c. NAME OF CEMETERY OR CREMATORIAL St. Marks		22d. LOCATION (City, town, or county) Petersville, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Feete		24a. RECEIVED BY REGISTRAR DATE 10/24/1956	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Ely Beck	

TO DEPUTY DIRECTOR: At EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director for removal.

VS. A15ME(S)  
5M 9/55

11253 V. S

KEGEVLE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10325

## CERTIFICATE OF DEATH

10301

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-NR.LANDER</b>		c. LENGTH OF STAY IN 1b <b>18 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENMERRIE NURSING HOME</b>		d. STREET ADDRESS <b>510 Trail Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>AUSTIN</b>		First <b>L</b>	Middle <b></b>	Last <b>MICHAEL</b>	4. DATE OF DEATH <b>OCT. 12 1956</b>	Month <b>OCT.</b>	Day <b>12</b>	Year <b>1956</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22-1877</b>	9. AGE (In years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	12. IF UNDER 24 HRS. Hours <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FUNERAL DIRECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Funeral Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13. FATHER'S NAME <b>Frederick A. Michael</b>		14. MOTHER'S MAIDEN NAME <b>Alice BAKER</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-5902</b>		17. INFORMANT <b>Paul S. Michael</b>		216 Lindbergh Ave. Address <b>Frederick - Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia &amp; Chronic Cystitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. (c) DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under- lying cause last. <b>Senility &amp; advanced generalized arteriosclerosis.</b>						5 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) <b>—</b>		(County) <b>—</b> (State) <b>—</b>
21. I certify that I attended the deceased from <b>9/26</b> , 19 <b>56</b> , to <b>9/26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>9/26</b> , 19 <b>56</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Jefferson Mtn</b>		DATE SIGNED <b>10/12/56</b>
ACTUAL SIGNATURE <b>A. T. Brice</b>				M.D.				
PHYSICIAN'S NAME (Type) <b>A. T. Brice</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-14-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick</b>		(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		W. <b>Frederick - Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Eliz. H. Herb</b>		24b. REGISTRAR'S SIGNATURE
						DATE <b>5 Oct 1956</b>		

Y. V. E. E. E. Y.

1956. 1. 1. 1956

CEV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1032610302  
147

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT FREDERICK MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT AIRY RD 2</b>		c. LENGTH OF STAY IN 1b <b>YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>D</b>	Middle <b>GRANT</b>	Last <b>MILLER</b>
4. DATE OF DEATH	Month <b>OCT</b>	Day <b>20</b>	Year <b>1956</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/5/1870</b>
9. AGE (In years lost birthday) <b>86 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER OWNER RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>DANIEL MILLER</b>	14. MOTHER'S MOTHER'S MAIDEN NAME <b>SARAH REESE</b>	Address <b>JOSIAH MILLER UNIONVILLE, MD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>NCNE</b>	17. INFORMANT <b>JOSIAH MILLER</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Non operable Prostate.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 6, 1956</b> to <b>Oct 20, 1956</b> , that I last saw the deceased alive on <b>Oct 20, 1956</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ADDITIONAL INFORMATION</b>	DATE SIGNED <b>10-21-56</b>		
ACTUAL SIGNATURE <b>J. H. Legg MD</b>	M.D.		
PHYSICIAN'S NAME (Type) <b>J. H. Legg MD</b>	22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 10/22/56		
22b. DATE THEREOF <b>10/22/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>LINGANORE</b>	22d. LOCATION (City, town, or county) <b>UNIONVILLE</b>	(State) <b>MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. R. Hartley &amp; Sons Union Bridge MD</b>	ADDRESS <b>100 Hartley &amp; Sons Union Bridge MD</b>	24a. REC'D BY REGISTRAR <b>ACT 22 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Mrs. Cleoie Bunkley</b>

YUDEAU V. A.

OCT 28 1956

11/25

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10303

Reg. Dist. No. 131

10327

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director. File pages 1 and 2 with the Registrar prior to removal.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Pa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg, Frederick</u>		b. COUNTY <u>Bed. Co</u>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Everette, Pa.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Emmitsburg Memorial Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Franklin Miller</u>		4. DATE OF DEATH <u>Oct. 22 1956</u>	Month <u>Oct.</u> Day <u>22</u> Year <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1933</u>
			9. AGE (in years last birthday) <u>23</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction, Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Providence T. S. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Miller</u>		14. MOTHER'S MAIDEN NAME <u>Anna May Potts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>D N K</u>	
17. INFORMANT <u>Hospital Records, (Same as item # 1)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture skull over left temporal region</u>			
DUE TO <u>816X</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest of left side</u>			
DUE TO			
(c) <u>Fracture of lower jaw right side</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Auto accident head on collision</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Frontal impact</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>12</u> o. m. <u>10/22 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u>
20f. (City or town) <u>Emmitsburg, Md</u>		(County) <u>Frederick Co</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. J. Thomas</u>		DATE SIGNED <u>Oct. 22-56</u>	
EXAMINER'S NAME (Type) <u>B. J. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>25 Oct. 1956</u>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Everette, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>Elizabeth H. Heck</u>	
VS. A15ME(S) 5M 9/55		24b. REGISTRAR'S SIGNATURE	

RECEIVED  
BUREAU V. S.

OCT 24 1965

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10304  
131

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained by the funeral director for removal.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN LIFE TIME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 122-5½ Street				d. STREET ADDRESS 122-5½ Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Harry	Middle Blaine	Last Morgan	4. DATE OF DEATH Oct 4 1956	Month	Day	Year
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 7, 1884		9. AGE (in years last B'DAY) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contracting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Peter Morgan			14. MOTHER'S MAIDEN NAME Rosanna Hoffman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-14-2624		17. INFORMANT Mrs LeRoy Sowell 131 S. Market St, Frederick, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Congestive heart failure with pulmonary edema Chronic rheumatic heart disease 5 yrs + Aortic stenosis				
19. INTERVAL BETWEEN SET AND DEATH 1/2 hour								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>R. Etchison</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) B.O. THOMAS		10/5/56						
22a. BURIAL, CREMATION: REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison and Son, Frederick, Md.		24a. REC'D BY REGISTRAR DATE 5 Oct 1956 24b. REGISTRAR'S SIGNATURE <i>Elizabeth H. Hank</i>						

PUNJAB V. 3

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10328

## CERTIFICATE OF DEATH

10305

Reg. Dist. No.

133

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>61 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Smithsburg</b>	
3. NAME OF DECEASED (Type or print) <b>Keller Hiram Moser</b>		d. STREET ADDRESS <b>Foxville</b>	
4. DATE OF DEATH <b>October 31</b>		Month	Day
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>April 1, 1895</b>		9. AGE (in years last birthday) <b>61</b>	10. IF UNDER 1 YEAR Months <b>0</b>
11. IF UNDER 24 HRS. Days <b>0</b>		12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rubber factory</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Lewis Moser</b>		14. MOTHER'S MAIDEN NAME <b>Viola Hayes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>World War I 215-12-9138</b>	17. INFORMANT <b>Mrs. John Fox</b>
		Address <b>Lantz, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure - Congestive type</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
48.2.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)		<b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of the liver.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>0</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Thurmont</b>		(County) <b>Md.</b> (State)	
21. I certify that I attended the deceased from <b>June 15, 1953</b> to <b>Oct. 30, 1954</b> , that I last saw the deceased alive on <b>Oct. 30, 1954</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b>	
ACTUAL SIGNATURE <b>James K. Gray</b>		DATE SIGNED <b>11-1-56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James K. Gray</b>		22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>11-4-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Bethel M.E.</b>	22d. LOCATION (City, town, or county) <b>Foxville Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thurmont Cremans</b>		ADDRESS <b>Thurmont, Md.</b>	
		24a. REC'D BY REGISTRAR DATE <b>11-5-56</b>	24b. REGISTRAR'S SIGNATURE <b>Oneeta Wolfe</b>

GRÉAU V. G.

7-5-1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10306

10301

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 West Fourth Street				d. STREET ADDRESS 118 West Fourth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle WASHINGTON	Last MYERS	4. DATE OF DEATH October 2, 1956	Month October	Day 2,	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 26, 1867		9. AGE (in years from birth) 80 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		10b. KIND OF BUSINESS OR INDUSTRY City Police		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Sterlie L. Myers, Frederick, Maryland		565 East Church Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH Commence							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>Jan.</i> 1952, to <i>Oct. 2</i> 1956, that I last saw the deceased alive on <i>Oct. 1</i> 1956, and that death occurred at 10:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Professional Bldg., Frederick, Md.</i> DATE SIGNED <i>10/4/56</i>							
ACTUAL SIGNATURE <i>G. D. Thomas</i>	M.D. Professional Bldg., Frederick, Md. 10/4/56						
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Sr.	Same as above						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 5, 1956	22c. NAME OF CEMETERY OR CREMATORIAL McKaig Cemetery	22d. LOCATION (City, town, or county) (State) Frederick County, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE 5 Oct. 1956	24b. REGISTRAR'S SIGNATURE <i>Elizabeth H. Heck</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be referred to the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with  
the registrar prior to 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10302

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Lifetime</b>		d. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>318 Chapel Street</b>		e. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
3. NAME OF -DECEASED (Type or print) <b>IRA</b>		First <b>IRA</b> Middle <b>GROVER</b> Last <b>NUSZ</b>		4. DATE OF DEATH October 7 1956		Month <b>October</b> Day <b>7</b> Year <b>1956</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 22, 1884</b>		9. AGE (in years last birthday) <b>72</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron &amp; Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William L. Nusz</b>		14. MOTHER'S MAIDEN NAME <b>Mollie M. Eichner</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-3495</b>		17. INFORMANT <b>Mr. Charles W. Nusz - 5610 Clearspring Road</b>		Address <b>Baltimore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <i>Bronchitis</i>							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause (b). <b>b.</b>		DUE TO <b>c.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>a. m.</b> <b>p. m.</b>		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>B. O. Thomas</i>									
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 10, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Clincher Son</i>		ADDRESS <i>Frederick, Md.</i>		24a. REC'D BY REGISTRAR <b>10 Oct. 1956</b>		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Hark</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by the funeral director. File Pages 1 and 2 with the registrar prior to burial or removal.

BUREAU V. S.

OCT 15 1956

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**10303 CERTIFICATE OF DEATH**

10308  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>18 Clark Place</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b>		First <b>7.</b>	Middle <b>PALMER</b>
4. DATE OF DEATH <b>October 25</b>		Last <b>1956</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 19, 1871</b>
8. IF UNDER 1 YEAR Months <b>8</b>		9. AGE (In years from birth) <b>81 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Worked for Farmers</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas F. Palmer</b>		14. MOTHER'S MAIDEN NAME <b>Susann R. Wachter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>No</b>		16. SOCIAL SECURITY NO <b>213-16-1526</b>	
17. INFORMANT <b>Gordon F. Palmer</b>		Address <b>18 Clark Place</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paroxysm of asthma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
155 x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
155 x DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1952, to 10/25, 1956, that I last saw the deceased alive on 10/5, 1956, and that death occurred at 2:00 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>228 N. Market St.</b>	
ACTUAL SIGNATURE <b>James B. Thomas, M.D.</b>		DATE SIGNED <b>10/25/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James B. Thomas</b>			
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-27-56</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Lewistown Cemetery</b>		22d. LOCATION (City, town, or county) <b>Lewistown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond S. Greager</b>		ADDRESS <b>Thurmont, Md</b>	
24a. REC'D BY REGISTRAR <b>Eligible G. Herb</b>		24b. REGISTRAR'S SIGNATURE	
DATE 26 Oct 1956			

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RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10329

## CERTIFICATE OF DEATH

10329  
3

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Frederick-Rt.2</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Chester Leon Redmond-Sr.</b>		4. DATE OF DEATH <b>Oct. 13 1956</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-29-1903</b>
9. AGE (in years from birthdate) <b>53 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brush Factory</b>	11. BIRTHPLACE (State or Foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harry W. Redmond</b>	
14. MOTHER'S MAIDEN NAME <b>Mollie Suman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-10-1897</b>		17. INFORMANT <b>Chester L. Redmond-Jr.-Route 6-Frederick-Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Arteric Stenosis</b>		5 yrs +	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> to <b>Oct. 13 1956</b> that I last saw the deceased alive on <b>Oct. 13 1956</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg.-Frederick-Md.</b> DATE SIGNED <b>10/15/56</b>			
ACTUAL SIGNATURE <b>B.O.Thomas</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. B.O.Thomas-Sr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 16-1956</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick- Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.E.Cline &amp; Son</b>		24a. RECD BY REGISTRAR DATE <b>15 Oct. 1956</b>	
ADDRESS <b>Frederick-Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heber</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director.  
Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, fold in half, and file with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

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PROPERTY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10310

10304

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 16 <i>62 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
3. NAME OF DECEASED (Type or print) <i>Paul B. Phoads</i>		d. STREET ADDRESS <i>127 East Patrick St</i>	
3. NAME OF DECEASED (Type or print) <i>Paul B. Phoads</i>		4. DATE OF DEATH <i>Oct 29</i>	Month <i>Oct</i> Day <i>29</i> Year <i>1956</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 19 1894</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) <i>62 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>VARIETY STORE</i>	
10c. BIRTHPLACE (State or foreign country) <i>Ind</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles M Phoads</i>		14. MOTHER'S MAIDEN NAME <i>Mary Anna Holler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO <i>220-05-6278</i>	
17. INFORMANT <i>Louis S Rhoads</i>		Address <i>Frederick Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>400.1</i> DUE TO Acute Coronary thrombosis with infarction of the myocardium.		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO Hypertensive cardio-vascular disease.		10 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>400.1 Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb.</i> , 1954, to <i>10/29/56</i> , that I last saw the deceased alive on <i>10/28/56</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1. E. Church St., Frederick, Maryland.</i>		DATE SIGNED <i>10/29/56</i>	
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>			
22a. BURIAL, Cremation (Specify) <i>Burial Oct 31, 1956</i>		22b. DATE THEREOF <i>Oct 31, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Frederick Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harold C. Early</i>		ADDRESS <i>Frederick Md</i>	
24a. REC'D BY REGISTRAR DATE <i>30 Oct 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Elig. B. Hock</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, the funeral director will file the certificate in the funeral home. It should be filed within 24 hours after death.

3 should be detached for use as the burial-transit permit. Then please file the certificate in the funeral home. It should be filed within 24 hours after death.

As registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10311

10305

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 316 W. South Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) William Williams		First Middle Last	4. DATE OF DEATH October 27 Month Day Year 19 56
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		9. AGE (In years from birthday) 86 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Contractor		10. BIRTHPLACE (State or foreign country) Frederick, Co. Md.	
11. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Frank F. Roberts		14. MOTHER'S MAIDEN NAME Mariah Castle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ada Roberts		Address 316 W. South Street	
18. CAUSE OF DEATH [Enter only one cause pending for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-6, 1956, to 10-27, 1956, that I last saw the deceased alive on 10-27, 1956, and that death occurred at 5:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE U.G. Bourne Jr. M.D. F. DATE SIGNED 10-29-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30-56	
22c. NAME OF CEMETERY OR CREMATORIUM Fairview		22d. LOCATION (City, town, or county) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Hicks III		ADDRESS Frederick- Md.	
24a. REC'D BY REGISTRAR DATE 30 Oct. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Hicks	

HOSPITAL  ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be held for use as the burial-transit permit. Then please remove, retain, or removal, and in any event within 72 hours after death.

TO THE REGISTRAR: After this certificate has been signed by the attending physician, it should be filed with the registrar prior to the time of burial.

VS A15 (4)  
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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10306 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 131

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director.

UNIVERSITY DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with removal.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN lb <b>3 hours</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>215 Army Hospital, Ft. Detrick, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TANNERTOWN, Md (Unionbridge)</b>		
3. NAME OF DECEASED (Type or print) <b>Milton Ames</b>		d. STREET ADDRESS <b>RURAL</b>		
4. DATE OF DEATH <b>10 Oct 1956</b>	Month <b>Oct</b>	Day <b>10</b>	Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 Nov 1925</b>	
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>30 yrs</b>	10. IF UNDER 1 YEAR Months <b>11</b> Days <b>4</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>Samuel M Six</b>		
14. MOTHER'S MAIDEN NAME <b>FRANCES I GARBER</b>	Address <b>WHA B Six TANNERTOWN, Md</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>216-05-0885</b>		17. INFORMANT <b>WHA B Six TANNERTOWN, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  (b) <u>Sub-acute cerebral hemorrhage -</u> DUE TO <u>Acute pulmonary Edema</u> (c)				
INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				
ACTUAL SIGNATURE <i>B.C. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>10/10/56</i>
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct 13-1956</b>	22c. NAME OF CEMETERY OR CEMETORY <b>Pipe Creek</b>	22d. LOCATION (City, town, or county) <b>Carroll Co</b>	(State) <b>Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. Hertzberg &amp; Sons, Union Bridge, Md</i>	ADDRESS	24a. REC'D BY REGISTRAR <b>Elizabeth H. Head</b>	DATE <b>13 Oct 1956</b>	24b. REGISTRAR'S SIGNATURE

BUREAU V.

OCT 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 131

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be signed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with  
 the funeral director.  
**3 should be detached for use as the burial/transit permit. Then please remove carbon papers and file with the funeral director.**  
**4** **5** **6** **7** **8** **9** **10** **11** **12** **13** **14** **15** **16** **17** **18** **19** **20** **21** **22** **23** **24** **25** **26** **27** **28** **29** **30** **31** **32** **33** **34** **35** **36** **37** **38** **39** **40** **41** **42** **43** **44** **45** **46** **47** **48** **49** **50** **51** **52** **53** **54** **55** **56** **57** **58** **59** **60** **61** **62** **63** **64** **65** **66** **67** **68** **69** **70** **71** **72** **73** **74** **75** **76** **77** **78** **79** **80** **81** **82** **83** **84** **85** **86** **87** **88** **89** **90** **91** **92** **93** **94** **95** **96** **97** **98** **99** **100** **101** **102** **103** **104** **105** **106** **107** **108** **109** **110** **111** **112** **113** **114** **115** **116** **117** **118** **119** **120** **121** **122** **123** **124** **125** **126** **127** **128** **129** **130** **131** **132** **133** **134** **135** **136** **137** **138** **139** **140** **141** **142** **143** **144** **145** **146** **147** **148** **149** **150** **151** **152** **153** **154** **155** **156** **157** **158** **159** **160** **161** **162** **163** **164** **165** **166** **167** **168** **169** **170** **171** **172** **173** **174** **175** **176** **177** **178** **179** **180** **181** **182** **183** **184** **185** **186** **187** **188** **189** **190** **191** **192** **193** **194** **195** **196** **197** **198** **199** **200** **201** **202** **203** **204** **205** **206** **207** **208** **209** **210** **211** **212** **213** **214** **215** **216** **217** **218** **219** **220** **221** **222** **223** **224** **225** **226** **227** **228** **229** **230** **231** **232** **233** **234** **235** **236** **237** **238** **239** **240** **241** **242** **243** **244** **245** **246** **247** **248** **249** **250** **251** **252** **253** **254** **255** **256** **257** **258** **259** **260** **261** **262** **263** **264** **265** **266** **267** **268** **269** **270** **271** **272** **273** **274** **275** **276** **277** **278** **279** **280** **281** **282** **283** **284** **285** **286** **287** **288** **289** **290** **291** **292** **293** **294** **295** **296** **297** **298** **299** **300** **301** **302** **303** **304** **305** **306** **307** **308** **309** **310** **311** **312** **313** **314** **315** **316** **317** **318** **319** **320** **321** **322** **323** **324** **325** **326** **327** **328** **329** **330** **331** **332** **333** **334** **335** **336** **337** **338** **339** **340** **341** **342** **343** **344** **345** **346** **347** **348** **349** **350** **351** **352** **353** **354** **355** **356** **357** **358** **359** **360** **361** **362** **363** **364** **365** **366** **367** **368** **369** **370** **371** **372** **373** **374** **375** **376** **377** **378** **379** **380** **381** **382** **383** **384** **385** **386** **387** **388** **389** **390** **391** **392** **393** **394** **395** **396** **397** **398** **399** **400** **401** **402** **403** **404** **405** **406** **407** **408** **409** **410** **411** **412** **413** **414** **415** **416** **417** **418** **419** **420** **421** **422** **423** **424** **425** **426** **427** **428** **429** **430** **431** **432** **433** **434** **435** **436** **437** **438** **439** **440** **441** **442** **443** **444** **445** **446** **447** **448** **449** **450** **451** **452** **453** **454** **455** **456** **457** **458** **459** **460** **461** **462** **463** **464** **465** **466** **467** **468** **469** **470** **471** **472** **473** **474** **475** **476** **477** **478** **479** **480** **481** **482** **483** **484** **485** **486** **487** **488** **489** **490** **491** **492** **493** **494** **495** **496** **497** **498** **499** **500** **501** **502** **503** **504** **505** **506** **507** **508** **509** **510** **511** **512** **513** **514** **515** **516** **517** **518** **519** **520** **521** **522** **523** **524** **525** **526** **527** **528** **529** **530** **531** **532** **533** **534** **535** **536** **537** **538** **539** **540** **541** **542** **543** **544** **545** **546** **547** **548** **549** **550** **551** **552** **553** **554** **555** **556** **557** **558** **559** **560** **561** **562** **563** **564** **565** **566** **567** **568** **569** **570** **571** **572** **573** **574** **575** **576** **577** **578** **579** **580** **581** **582** **583** **584** **585** **586** **587** **588** **589** **590** **591** **592** **593** **594** **595** **596** **597** **598** **599** **600** **601** **602** **603** **604** **605** **606** **607** **608** **609** **610** **611** **612** **613** **614** **615** **616** **617** **618** **619** **620** **621** **622** **623** **624** **625** **626** **627** **628** **629** **630** **631** **632** **633** **634** **635** **636** **637** **638** **639** **640** 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**766** **767** **768** **769** **770** **771** **772** **773** **774** **775** **776** **777** **778** **779** **780** **781** **782** **783** **784** **785** **786** **787** **788** **789** **790** **791** **792** **793** **794** **795** **796** **797** **798** **799** **800** **801** **802** **803** **804** **805** **806** **807** **808** **809** **810** **811** **812** **813** **814** **815** **816** **817** **818** **819** **820** **821** **822** **823** **824** **825** **826** **827** **828** **829** **830** **831** **832** **833** **834** **835** **836** **837** **838** **839** **840** **841** **842** **843** **844** **845** **846** **847** **848** **849** **850** **851** **852** **853** **854** **855** **856** **857** **858** **859** **860** **861** **862** **863** **864** **865** **866** **867** **868** **869** **870** **871** **872** **873** **874** **875** **876** **877** **878** **879** **880** **881** **882** **883** **884** **885** **886** **887** **888** **889** **880** **881** **882** **883** **884** **885** **886** **887** **888** **889** **890** **891** **892** **893** **894** **895** **896** **897** **898** **899** **900** **901** **902** **903** **904** **905** **906** **907** **908** **909** **910** **911** **912** **913** **914** **915** **916** **917** **918** **919** **920** **921** **922** **923** **924** **925** **926** **927** **928** **929** **9210** **9211** **9212** **9213** **9214** **9215** **9216** **9217** **9218** **9219** **9220** **9221** **9222** **9223** **9224** **9225** **9226** **9227** **9228** **9229** **9230** **9231** **9232** **9233** **9234** **9235** **9236** **9237** **9238** **9239** **92310** **92311** **92312** **92313** **92314** **92315** **92316** **92317** **92318** **92319** **92320** **92321** **92322** **92323** **92324** **92325** **92326** **92327** **92328** **92329** **92330** **92331** **92332** **92333** **92334** **92335** **92336** **92337** **92338** **92339** **92340** **92341** **92342** **92343** **92344** **92345** **92346** **92347** **92348** **92349** **92350** **92351** **92352** **92353** **92354** **92355** **92356** **92357** **92358** **92359** **92360** **92361** **92362** **92363** **92364** **92365** **92366** **92367** **92368** **92369** **92370** **92371** **92372** **92373** **92374** **92375** **92376** **92377** **92378** **92379** **92380** **92381** **92382** **92383** **92384** **92385** **92386** **92387** **92388** **92389** **92390** **92391** **92392** **92393** **92394** **92395** **92396** **92397** **92398** **92399** **923100** **923101** **923102** **923103** **923104** **923105** **923106** **923107** **923108** **923109** **923110** **923111** **923112** **923113** **923114** **923115** **923116** **923117** **923118** **923119** **923120** **923121** **923122** **923123** **923124** **923125** **923126** **923127** **923128** **923129** **923130** **923131** **923132** **923133** **923134** **923135** **923136** **923137** **923138** **923139** **923140** **923141** **923142** **923143** **923144** **923145** **923146** **923147** **923148** **923149** **923150** **923151** **923152** **923153** **923154** **923155** **923156** **923157** **923158** **923159** **923160** **923161** **923162** **923163** **923164** **923165** **923166** **923167** **923168** **923169** **923170** **923171** **923172** **923173** **923174** **923175** **923176** **923177** **923178** **923179** **923180** **923181** **923182** **923183** **923184** **923185** **923186** **923187** **923188** **923189** **923190** **923191** **923192** **923193** **923194** **923195** **923196** **923197** **923198** **923199** **923200** **923201** **923202** **923203** **923204** **923205** **923206** **923207** **923208** **923209** **923210** **923211** **923212** **923213** **923214** **923215** **923216** **923217** **923218** **923219** **923220** **923221** **923222** **923223** **923224** **923225** **923226** **923227** **923228** **923229** 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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No.

137

1. PLACE OF DEATH a. COUNTY <i>FREDERICK</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>MARYLAND</i>		b. COUNTY <i>WASHINGTON</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DIXIE GREEN ROAD RURAL</i>		c. LENGTH OF STAY IN 1b <i>2 YEARS - 6 MO</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MT. LENA - RURAL</i>		d. STREET ADDRESS <i>BOONSBORO MD. R-2-</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MIDDLETON MD. R-1</i>				d. STREET ADDRESS <i>BOONSBORO MD. R-2-</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>DAVID</i>		First	Middle	Last	4. DATE OF DEATH <i>OCTOBER - 18, 1956</i>	Month	Day	Year	
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>NOV. 2 - 1871</i>	9. AGE (In years lost birthday) <i>84-11-18</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED FRUIT GROWER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN FARM</i>		11. BIRTHPLACE (State or foreign country) <i>NEAR Boonsboro WASH. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>MD. U.S.A.</i>			
13. FATHER'S NAME <i>WILLIAM SOUDERS</i>		14. MOTHER'S MAIDEN NAME <i>SOPHIA WEDDLE</i>		Address <i>MRS. ELLEN SOUDERS MIDDLETON MD. R-1</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>IVNONE</i>		17. INFORMANT <i>MRS. ELLEN SOUDERS</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Severe Parkinsonism</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>MT. LENA</i>		(County) <i>Middle</i>	(State) <i>MD.</i>
21. I certify that I attended the deceased from <i>11/12</i> , 1955, to <i>10/17</i> , 1956, that I last saw the deceased alive on <i>10/17</i> , 1956, and that death occurred at <i>MT. LENA</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Kenneth C. Henson</i>		PHYSICIAN'S NAME (Type) <i>Kenneth C. Henson MD.</i>		ADDRESS <i>Middleton</i>		ADDRESS (Street, city or town, state) <i>MT. LENA CEMETERY</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>OCT. 21. 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>MT. LENA CEMETERY</i>		22d. LOCATION (City, town, or county) <i>MT. LENA WASH. D.C. MD.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>BEST FUNERAL HOME</i>		ADDRESS <i>Boonsboro MD</i>		24a. REC'D BY REGISTRAR <i>John H. Frost</i>		24b. REGISTRAR'S SIGNATURE <i>John H. Frost</i>			
VS A15 (4) 15M 9/55				DATE <i>Oct. 23. 1956</i>					

BUREAU Y.

OCT 25 1956

REGISTRY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the funeral director for cremation.

V.S. 11516(5)  
SM 9/35

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10315

Reg. Dist. No. 131

10331

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>6 months</i>		b. COUNTY <i>Bed. 1c</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saxton Rd. #1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. C. &amp; L. Hospital Hospital</i>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>William H. Stapleton</i>		First	Middle	4. DATE OF DEATH <i>October 22 1956</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>June 23, 1935</i>	9. AGE (In years less birthday) <i>21</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Raymond Stapleton</i>				14. MOTHER'S MAIDEN NAME <i>Mary Wyles</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>Unk</i>			
17. INFORMANT <i>Hospital Records</i>				Address (Same as item #1)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broken neck</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Fracture left thigh</i>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>London auto accident</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>10-22 1956</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Routine 40</i>		20f. (City or town) <i>6 miles N. Frederick</i>	
(County) <i>Frederick Co.</i>		(State) <i>Pennsylvania</i>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>B.C. Thomas</i>				DATE SIGNED 22, Oct, 1956			
EXAMINER'S NAME (Type) <i>B.C. Thomas</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>25 Oct 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>I. O. O. F. Cemetery</i>		22d. LOCATION (City, town, or county) <i>Saxton, Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. R. Etchison &amp; Son, Frederick, Maryland</i>				24a. REC'D BY REGISTRAR DATE <i>23 Oct 1956</i>			
				24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heck</i>			

BUREAU V. S.

DET. 01 1956

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10313

## CERTIFICATE OF DEATH

10316

Reg. Dist. No. 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial. Page 3 should be attached for use of the burial/trust permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 65 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		d. STREET ADDRESS 615 Brunswick St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 615 Brunswick St.				d. STREET ADDRESS 615 Brunswick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary		First	Middle Ellen	Last Stickley	4. DATE OF DEATH 10	Month Month	Day Day	Year Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1867	9. AGE (In years lost birthday) 89 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William T. Green				14. MOTHER'S MAIDEN NAME Mary Ellen Lynam				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ethel Mullen, Brunswick, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</b> <i>Arteriosclerosis.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Brunswick	(County)	(State)
21. I certify that I attended the deceased from <u>10/20/1967</u> to <u>10/31/1967</u> , that I last saw the deceased alive on <u>10/20/1967</u> , and that death occurred at <u>65</u> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. G. F. Smith</i>		ADDRESS (Street, city or town, state) Brunswick, Frederick, Maryland DATE SIGNED 11/1/68						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-3-1968	22c. NAME OF CEMETERY OR CREMATORIAL Park Heights			22d. LOCATION (City, town, or county) Brunswick, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. L. Fife</i>		ADDRESS Brunswick, Maryland						
VS A15 (4) 15M 9/55		24a. REC'D BY REGISTRAR 10/30/1968						
		24b. REGISTRAR'S SIGNATURE <i>Eugenia Bunker</i>						

## וְאַתָּה תְּבִרְכֵנִי

9561 5 16

תְּאַתְּ בָּנֵן

10308

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Route 5- Clifton</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Ethel</b>	Middle <b>Mercer</b>	Lost	4. DATE OF DEATH	Month <b>Oct.</b>	Day <b>5</b>	Year <b>19 56</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20-1890</b>	9. AGE (in years lost birthday) <b>65 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles E. Mercer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Stine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-8854</b>		17. INFORMANT <b>Mr. Wm. S. Stine- Route 5- Frederick-Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410.0</b> <i>Coronary occlusion</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- <b>Hours</b> lying cause lost.      (b) <i>Hypertensive arteriosclerotic heart disease</i> (c) <i>Years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>10/5</b>	(County)	(State)	
21. I certify that I attended the deceased from <b>2/13</b> , 19 <b>56</b> , to <b>10/5</b> , 19 <b>56</b> that I last saw the deceased alive on <b>10/5</b> , 19 <b>56</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Professional Bldg., Frederick-Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <i>James B. Thomas</i> M.D. <b>Professional Bldg., Frederick-Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-8-1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son</b>		W.	ADDRESS <b>Frederick-Maryland</b>		24a. REC'D BY REGISTRAR <b>Elizabeth G. Heck</b>	24b. REGISTRAR'S SIGNATURE	
VS AIS (4) 15M 9/55		DATE <b>8 Oct 1956</b>					

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
OCT 9 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10318

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Doubs		c. LENGTH OF STAY IN lb Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Doubs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pleasant View Road		d. STREET ADDRESS Pleasant View Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF -DECEASED (Type or print)	First JOSEPH	Middle NATHAN	Last TALBOTT	4. DATE OF DEATH	Month October	Day 3,	Year 1956
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1901	9. AGE (In years less birthday) 55 yrs.	10. UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Shoe Industry		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan T. Talbott			14. MOTHER'S MAIDEN NAME Hattie Wood				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Hilda P. Talbott, Doubs, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH Never</span>							
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="float: right;">(b) <u>Acute pulmonary edema.</u></span>							
DUE TO (b) <u>Acute pulmonary edema.</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Br. B. O. Thomas Sr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED 10/3/1956							
22a. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 6, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Monocacy Cemetery		22d. LOCATION (City, town, or county) Beallsville, Maryland		
(State)							
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland							
ADDRESS							
24a. REC'D BY REGISTRAR DATE 50 Oct 1956							
24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Tech</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for our files.

GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Director prior to removal.

VS. ATSM(S),  
SM 9/55

77000000

cont. 8-10



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10333

## CERTIFICATE OF DEATH

10319

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b Years (36)	b. COUNTY	
Adamstown	Years (36)	Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
		Adamstown	
d. STREET ADDRESS		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELIA	Middle VIRGINIA	Last THOMAS
4. DATE OF DEATH	Month October	Day 21,	Year 1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 29, 1860
9. AGE (In years lost birthday) 96	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Peter Thomas		14. MOTHER'S MAIDEN NAME Elizabeth R. Remsberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. G. Frank Thomas, Adamstown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio-sclerotic heart dis. w/paroxysmal arrhythmia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19			
21. I certify that I attended the deceased from _____, 1956, to 10/21, 1956, that I last saw the deceased alive on 21 OCT. 1956, and that death occurred at 10:10A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Professional Bldg. Frederick, Md. DATE SIGNED 10/24/56			
ACTUAL SIGNATURE Charles H. Conley		PHYSICIAN'S NAME (Type) Dr. Charles H. Conley Jr.	
Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 24, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery	22d. LOCATION (City, town, or county) (State) Frederick County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 24 Oct. 1956	24b. REGISTRAR'S SIGNATURE Elizabeth H. Heck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be rendered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-troussal permit. Then please remove carbon paper. If any event within 72 hours after death, it should be filed with the funeral director.

WILDEAU V. S.

1950

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10320

10334

## CERTIFICATE OF DEATH

Reg. Dist. No. 147

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Mt. Airy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeville		d. STREET ADDRESS Ridgeville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA		First A.	Middle THOMPSON
4. DATE OF DEATH 10- 27 - 1956	Month Day Year		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1--27--1864
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Ludwig		14. MOTHER'S MAIDEN NAME Catherine Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Howard E. Thompson, same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>56</u> , to <u>October 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>October 23</u> , 19 <u>56</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, City or town, state) M.D. <u>James P. Kerr</u> <u>11amascus, Md.</u> DATE SIGNED <u>10/28/56</u>			
ACTUAL SIGNATURE <u>James P. Kerr</u>		PHYSICIAN'S NAME (Type) James P. Kerr	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-29-1956	22c. NAME OF CEMETERY Pine Grove	22d. LOCATION (City, town, or county) Mt. Airy, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	24a. REC'D BY REGISTRAR DATE Oct 30 1956
			24b. REGISTRAR'S SIGNATURE <u>Grace Runkles</u>

BUREAU Y. S.

OCT 31 1956

KELLOGG

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10321

10309

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 wk.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Walkersville</i>	
3. NAME OF DECEASED (Type or print) <i>ELLA</i>		d. STREET ADDRESS	
First <i>C.</i>		Middle <i>VALENTINE</i>	4. DATE OF DEATH <i>Oct 6 1956</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 1, 1871</i>
9. AGE (in years lost birthday) <i>85 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Samuel Crouse</i>		14. MOTHER'S MAIDEN NAME <i>Martha Shriver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Lola Johnson, Walkersville</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Anterosclerotic cardiovascular disease (c) INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>—</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>FRACTURE LEFT FEMUR</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1 April 1948</i> to <i>6 Oct 1956</i> , that I last saw the deceased alive on <i>6 October 1956</i> , and that death occurred at <i>7:35 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James S. Stover, Jr.</i>		ADDRESS (Street, city or town, state) <i>Walkersville, Md 20501</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 9, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Chapel</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Burton, Walkersville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>10 Oct 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Heek</i>

BUREAU V. S.

OCT 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4  
 may be read by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10310

## CERTIFICATE OF DEATH

10322

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>240 East Sixth Street</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle <b>W.</b>	Last <b>WACHTER</b>	4. DATE OF DEATH	Month <b>October</b>	Day <b>20</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	8. DATE OF BIRTH <b>November 23, 1876</b>	9. AGE (in years last birthday) <b>79 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Street Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY: <b>USA</b>	
13. FATHER'S NAME <b>Uriah Wachter</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Frances. C. Summers,</b>		249 Fast Sixth Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO <i>Arteriosclerotic and rheumatic cardio- vascular disease</i>				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>M.D. East Church Street, Frederick, Md.</b>	(County) <b>Jefferson</b>	(State) <b>Maryland</b>		
21. I certify that I attended the deceased from <b>7-18</b> , 1956, to <b>Oct 20</b> , 1956, that I last saw the deceased alive on <b>Oct. 18</b> , 1956, and that death occurred at <b>11:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. East Church Street, Frederick, Md.</b> DATE SIGNED <b>10/22/56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>Oct. 23, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) <b>Jefferson</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>Eliz. H. Heis</b>		24b. REGISTRAR'S SIGNATURE <b>DATE 22 Oct 1956</b>	

TOREAU Y. S

OCT 22 1976

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10323

10311

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived a. STATE Maryland		If institution: Residence before admission b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 16 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 236 East Church Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 236 East Church Street										
3. NAME OF DECEASED (Type or print)		First BESSIE	Middle JANE	Last WILCOX	4. DATE OF DEATH October 7, 1956	Month October	Day 7	Year 1956		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1895	9. AGE (In years last birthday 61 yrs.)	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or Foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Charles Marshall		14. MOTHER'S MAIDEN NAME Sarah May								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John E. Wilcox, Sr., (Same as item #1)		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Diabetes								
DUE TO (b)		Coronary heart disease								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Lewistown		(County)	(State)	
21. I certify that I attended the deceased from 3/19/1954 to 10/7/1956, that I last saw the deceased alive on 10/6/1956, and that death occurred at 10:30 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 10/9/56		
ACTUAL SIGNATURE <i>H. J. Slusher, M.D.</i>										
PHYSICIAN'S NAME (Type) H. J. Slusher, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10 Oct 1956		22c. NAME OF CEMETERY OR CREMATORIUM Methodist Cemetery		22d. LOCATION (City, town, or county) Lewistown, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS				24a. REC'D BY REGISTRAR DATE 9 Oct 1956		24b. REGISTRAR'S SIGNATURE <i>Elizabeth G. Herk</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with  
the physician, and then be filed in the funeral director's office. It should be filed within 24 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10324

10335

## CERTIFICATE OF DEATH

Reg. Dist. No.

145

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Frederick		Maryland		6 days		a. STATE Maryland	
						b. COUNTY Frederick	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
						Rural- Myersville	
						d. STREET ADDRESS	
						Route #1	
						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First DIANNE		Middle SUE		Last WOLFE	
4. DATE OF DEATH		Month October		Day 7		Year 1956	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH September 26, 1956	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
none				Frederick, Md.		U.S.A.	
13. FATHER'S NAME Daniel M. Wolfe		14. MOTHER'S MAIDEN NAME Mary A. Stahl					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		none		Daniel M. Wolfe, Myersville, Md. Rt. #1.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bronchial Pneumonia					
491X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)							
DUE TO							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 6, 1956, to Oct 7, 1956, that I last saw the deceased alive on Oct 6 (9pm), 1956, and that death occurred at 11:30 PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE J. Elmer Harp						DATE SIGNED	
PHYSICIAN'S NAME (Type)		J. Elmer Harp		Middletown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/9/1956		22c. NAME OF CEMETERY OR CREMATORIUM Church of the Brethren Harmony, Fred. Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul J. Bittle		ADDRESS Myersville, Md.		24a. REC'D BY REGISTRAR DATE 10-9-1956		24b. REGISTRAR'S SIGNATURE Sley M. Bittle	

DEPARTMENT OF STATE  
CABLEGRAM OF DETAIL

RECEIVED  
BUREAU V.  
OCT 10 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10312

## CERTIFICATE OF DEATH

10325

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>231 Washington Street</b>		e. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>ELMER</b>		First <b>DWIGHT</b>	Middle <b>ZIMMERMAN</b>
4. DATE OF DEATH <b>October 8 1956</b>	Month <b>October</b>	Day <b>8</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 24, 1885</b>
			9. AGE (In years lost birthday) <b>71</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor-Dining Hall</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>College</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George A. B. Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Ida B. Corbitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Grace Z. Keyes</b>		Address <b>Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>430.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
DUE TO <b>Myocardial infarction</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Coronary sclerosis</b>		DUE TO <b>10 years</b>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 8 1948</b> , to <b>Oct 8 1956</b> , that I last saw the deceased alive on <b>Oct 8 1956</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>S. L. Schoolman</b>		ADDRESS (Street, city or town, state) <b>228 N Market St Frederick MD</b> DATE SIGNED <b>10-8-78</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 11, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. E. Elsner &amp; Sons</b>		ADDRESS <b>Frederick, Md.</b>	
		24a. REC'D BY REGISTRAR <b>11 Oct 1956</b>	
		24b. REGISTRAR'S SIGNATURE <b>Elizabeth H. Hock</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with  
3. stamp to be detached for use as the burial-transit Permit. Then please remove carbon papers.  
register price

OPTIONAL FORM OF STATEMENT OF DEBT

BUREAU U.S.

OCT 15 1956

RECEIVED